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How Will International Trade Agreements Affect Canadian Health Care?

by

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Highlights

- The most important provisions of the international trade liberalization agreements in terms of their potential impact on the organization and structure of the Canadian health system are the national treatment and nationalization/expropriation provisions of the investment provisions of the *North American Free Trade Agreement* (NAFTA).

- The Canadian public health care system is largely shielded from the NAFTA national treatment provisions by reservations, but the effectiveness of these may erode over time.

- The Canadian public health care system is not shielded from the NAFTA nationalization/expropriation provisions, which have no effect on the system in its present form but could impede its expansion into areas currently served by private interests, particularly private health insurers, if those private interests are excluded.

- Canada has assumed market access and national treatment commitments respecting health insurance under the *General Agreement on Trade in Services* (GATS) that have potential impact on the Canadian public health care system. However, the purely public component of the Canadian health care system is excluded from GATS obligations by reason of being a service supplied in the exercise of governmental authority.

- The potential effect of the NAFTA investment provisions is compounded by the private rights of action conferred by NAFTA on U.S. and Mexican investors. However there are no private rights of action under the GATS or under any other agreement under the WTO.

- It is easy to invent NAFTA and WTO worst-case scenarios but the actual impact of these agreements must be assessed realistically. An expansion of the public component of the health care system into new areas, with the resulting exclusion of private interests, would result in NAFTA compensation claims or WTO challenges only if the private economic interests adversely affected were significant. If these interests are non-existent or insignificant, the risk of claims or challenges is negligible. Canada cannot be forced under any trade liberalizing agreement to change its laws.

- Some other provisions of the trade liberalizing agreements, such as those respecting pharmaceutical patents, have a potential indirect effect on the public health care system by affecting costs.

- The effect of other provisions of these agreements on Canada's public health care system is negligible.

Executive Summary

The purpose of this paper is to respond to the following questions posed by the Commission on the Future of Health Care in Canada:

General Question

Given that there are conflicting legal opinions concerning the extent to which Canada's public health care system is exempted or protected from the obligations imposed by international trade liberalization agreements, what options exist to ensure that Canadian governments may continue, if they so choose, to maintain a public health care system that is consistent with Canada's international trade agreements?

Specific Questions

1) Which of the major international trade liberalization agreements are most important in terms of their potential impact on the organization and structure of the Canadian health system(s)?

2) To what extent is the fact that the organization and delivery of services is a provincial responsibility while it is the federal government that negotiates international trade agreements relevant to understanding how these agreements will affect public health care delivery in Canada?

3) What are the most important opportunities and challenges facing governments, stakeholders and health care providers with regard to these international agreements?

4) What is the real impact of international economic and commercial agreements on the organization, financing, and governance of the Canadian health care system? How does this impact compare with the conditions that were prevalent when the national hospital insurance system or Medicare was implemented?

Essential Characteristics of Canada's Public Health Care System

The Canadian public health care system requires that *insured health services*, as defined by legislation, must be covered a health insurance plan administered by a provincially-designated public authority. The public authority must pay for all insured health services, and private insurers are excluded from this market. However, private insurers provide coverage for health services that are not insured health services. Insured health services can be and are delivered by private individuals and firms operating both on a non-profit and for-profit basis. Non-insured health services are provided by private individuals and firms and are paid for either directly by patients or through insurance plans operated by private insurers.

Most Important International Trade Liberalization Agreements (Question 1)

The most important international trade liberalization agreements in terms of their potential impact on the organization and structure of the Canadian health system are the *North American Free Trade Agreement* (NAFTA) and the *Agreement Establishing the World Trade Organization* (WTO Agreement).

The most important NAFTA provisions are the investment provisions requiring compensation for nationalization or expropriation of investments of U.S. and Mexican investors and requiring that no less favourable treatment (i.e. national treatment) be accorded to U.S. and Mexican investors and their investments. Canada's health care system is largely shielded from the full impact of the national treatment obligation by the Annex I reservation that grandfathers all non-conforming provincial measures existing on January 1, 1994 and by an Annex II reservation that covers health services established or maintained for a public purpose. The expropriation provision is not covered by reservations. U.S. and Mexican investors have direct rights of action against the Canadian government for breaches of these provisions.

The most important provisions of the WTO Agreement are the market access and national treatment obligations set out in the *General Agreement on Trade in Services* (GATS). These obligations apply to sectors respecting which Canada has assumed obligations, which include health insurance services. The purely public component of the Canadian health care system is excluded from GATS obligations by reason of being a service supplied in the exercise of governmental authority. Unlike NAFTA Chapter Eleven, the GATS confers no direct rights of action on private entities.

NAFTA and the GATS also contain monopoly provisions, which are relevant but not onerous. WTO and NAFTA intellectual property provisions affect health care costs but do not affect Canada's ability to maintain its public system. The WTO subsidies rules eliminate the possibility of countervail action against Canada's public system. The effect of the other WTO and NAFTA provisions is negligible.

Provincial Responsibility (Question 2)

The relevant provisions of the trade liberalizing agreements just described apply equally to provincial as well as federal measures.

Opportunities and Challenges (Question 3)

The trade liberalizing agreements present more challenges than opportunities. These agreements create opportunities in export markets, although the development of the ability to service export markets may have an indirect beneficial effect on domestic health care. The trade liberalizing agreements do not threaten the public health care system in its current form. However, an expansion of the public component of the system that excluded existing private sector providers could face the challenge of NAFTA compensation claims as constituting a nationalization. Increasing the private component of the system could erode the shield from full NAFTA national treatment requirements provided by the Annex I reservation. Further GATS commitments in health care sectors in the Doha round of WTO negotiations currently underway must be approached with caution. The *Free Trade Agreement of the Americas* (FTAA) negotiations may present challenges but may also present opportunities to clarify uncertainties under the NAFTA investment chapter.

Comparison with Conditions Prevalent when Medicare Established and Real Impact (Question 4)

Both NAFTA and the WTO Agreement came into force long after Medicare was established. The *General Agreement on Tariffs and Trade* pre-dated Medicare but had no effect on it. NAFTA national treatment obligations were new but the NAFTA expropriation provisions codified international law rules respecting state responsibility and respecting property of aliens that had pre-dated Medicare. However, in the event of a nationalization, the direct rights of action conferred by NAFTA on private investors make a claim for compensation far more likely than existed when Medicare became effective.

It is easy to invent NAFTA and WTO worst-case scenarios but the real impact of these agreements must be assessed realistically. An expansion of the public component into areas such as home care, to the exclusion of private insurers, would result in claims only if the economic interests affected were significant. If these interests are non-existent or insignificant, the risk of NAFTA compensation claims is negligible. NAFTA Chapter Eleven claims are very expensive for private investors to pursue and governments do not initiate WTO claims lightly. Canada cannot be forced under any trade liberalizing agreement to change its laws.

Options to Continue (General Question)

The most obvious option open to Canada to continue its public health care system is to maintain the *status quo*, without expansion or contraction of the public component. The option exists for expanding the public component into new areas that are ill-served by private interests and in which private economic interests are insignificant. Expansion into new areas where this is not the case could trigger compensation claims and prove to be impracticable. Increasing for-profit private sector involvement in the health care system must be approached with caution. Amending provincial laws to increase foreign involvement diminishes the shield provided by the Annex I reservation. Opening areas to for-profit firms that are currently the sole preserve of non-profit firms could trigger national treatment issues under NAFTA and, depending upon the state of Canada's commitments, the GATS. However, as to whether claims or challenges would actually result is another matter, and one that is capable of being assessed before a step in this direction is taken.

Introduction

Canada has been a party to multilateral trade agreements since 1948, when the *General Agreement on Tariffs and Trade* (now known as GATT 1947) entered into force. GATT 1947 and agreements elaborating certain of its provisions negotiated in successive rounds of GATT negotiations from 1948 to 1980 had a minimal effect on the manner in which Canada's health care system was organized.

Since those earlier GATT negotiating rounds, Canada has entered into trade liberalizing agreements that impose obligations that do place constraints on the ability of governments to organize the manner in which services are delivered. The *Canada-United States Free Trade Agreement* (CUFTA), which became effective on January 1, 1989, imposed obligations respecting services, investment and the designation of monopolies. The *North American Free Trade Agreement* (NAFTA), which superseded the CUFTA on January 1, 1994 and added Mexico as a party, elaborated upon the obligations respecting monopolies, expanded the services and investment obligations, and imposed new obligations respecting intellectual property.

Contemporaneously with the negotiation of the CUFTA and NAFTA, the Uruguay Round of GATT negotiations was completed. The Uruguay Round culminated in the *Marrakesh Agreement Establishing the World Trade Organization* (WTO Agreement), which came into effect on January 1, 1995. The Annexes to the WTO Agreement carry forward GATT 1947 as the *General Agreement on Tariffs and Trade 1994* (GATT 1994) as well as other agreements affecting trade in goods. The Annexes also set out entirely new agreements on trade in services and intellectual property, and establish a formal dispute resolution process within the institutional framework of the World Trade Organization (WTO).

Canada's Public Health Care System

While prime responsibility for health care in Canada is provincial, the basic structure of the Canadian public health care system is set out in the *Canada Health Act*. The *Canada Health Act* establishes criteria that must be satisfied for a province to qualify for a full cash contribution as part of the Canada Health and Social Transfer.

The Five Criteria Established by the Canada Health Act

In order to qualify, a province must satisfy the following five criteria:

- *Public Administration*: The province must establish a health care insurance plan administered by a public authority appointed or designated by the provincial government.

- *Comprehensiveness*: The health care insurance plan must insure all insured health services provided by hospitals, medical practitioners or dentists. Insured health services are defined in the Act as "hospital services", "physician services" and "surgical-dental services". These expressions are further defined in the *Canada Health Act*.

- *Universality*: A provincial health care insurance plan must entitle one hundred per cent of the insured persons in the province to the insured health services provided by the plan on uniform terms and conditions.

- *Portability*: The health insurance plan cannot impose any minimum period of residence or waiting period in excess of three months and must provide coverage for temporary absences.

- *Accessibility*: The plan must provide for insured health services on uniform terms and conditions. Payment must be in accordance with a tariff or system of payment authorized by the law of the province. The plan must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentist and for payment of amounts to hospitals. There are deductions from the cash transfer if the province permits extra-billing for insured health services by medical practitioners or dentists. Extra-billing is billing over and above the amount provided for the insured service under the health insurance plan.

The health insurance plans established in all the provinces follow this format.

Essential Characteristics of Canada's Public Health Care System from a Trade Agreement Perspective

The Canadian public health care system requires the establishment of a monopoly in each province to cover payment for all insured health services delivered within the province. Insured health services must be covered by a health insurance plan administered by a public authority designated by the province. The public authority must pay for all insured health services. The funding for payment can come wholly from public revenues or partly from premiums charged by the public authority, but user fees are prohibited. Whether by law or as a practical matter, insured services are not covered by plans administered by private insurers.[1]

The Canadian health care system is public in the sense that a public authority in each province pays for insured services. However, there is nothing in the *Canada Health Act* that prevents the supply of insured health services by private firms, whether non-profit or for-profit (Flood 1999, 31), and insured services are usually delivered by private individuals or firms. Medical practitioners and dentists are usually self-employed persons who usually operate as for-profit on a fee-for-service basis (Flood 1999, 31). While hospitals frequently receive the bulk of their funding from public sources, they are rarely government-owned. Most "public" hospitals are owned by non-profit firms (Flood 1999, 36).

While private individuals and firms deliver insured services, these service providers cannot contract with patients for the price of the service and can only receive the price for each insured service provided that is fixed by provincial law. Service providers usually bill the public authority directly. If a service provider bills a patient, the bill must be for the amount prescribed by the public authority and the patient receives reimbursement from the public authority.

The insured health services defined in the *Canada Health Act* and elaborated upon in provincial legislation do not cover the totality of health services. Many health services are not insured health services. For example, in the case of dentistry, the only dental services that are insured health services are surgical-dental procedures performed by a dentist in a hospital. Insured services include the cost of drugs provided in hospitals but not the cost of drugs provided outside of hospitals. Non-necessary medical procedures, such as cosmetic surgery, are not insured health services. Private insurers provide coverage for these non-covered services, and non-covered services are provided by private firms including for-profit firms.

Objectives of the Trade-Liberalizing Agreements

The trade liberalizing agreements have as their prime objectives the liberalization of trade in goods and services and the protection of direct foreign investment, as well as the protection of intellectual property rights. The means by which these agreements achieve the objectives of trade liberalization and investment protection is through placing limits upon governmental action. These limits take the form of non-discrimination requirements and, in some instances, the establishment of norms to which government measures must conform. These agreements generally favour market-based as opposed to government-administered structures in the areas that they impose obligations. However, the trade liberalizing agreements expressly permit the designation of monopolies and recognize, albeit subject to qualifications, the right of governments to regulate.

Major Trade Liberalizing Agreements with Potential Impact

The trade liberalizing agreements with the most significant potential impact on the organization and structure of the Canadian health care system are NAFTA[2] and several agreements (WTO agreements) set out in the Annexes of the WTO Agreement, most notably the *General Agreement on Trade in Services* (GATS).[3]

Provincial Responsibility Under the Trade Liberalizing Agreements

The trade liberalizing agreements generally require that the federal government ensure compliance by provincial and local governments. NAFTA Article 105 requires each NAFTA Party to ensure that all necessary measures are taken in order to give effect to NAFTA provisions, including (except where otherwise provided) their observance by provincial governments. A number of WTO agreements, notably the *General Agreement on Trade in Services* (GATS) and GATT 1994,[4] set out express provisions requiring that Member countries ensure compliance by regional governments.

Compliance by provincial governments may be taken as the general rule both under NAFTA and the WTO agreements, but there are significant exceptions. This paper will identify, with each agreement considered, whether and the extent to which it applies to provincial measures.

Relevant Provisions of the Trade Liberalizing Agreements

The provisions of the trade-liberalizing agreements that affect Canada's public health care system may be briefly summarized as follows:

Monopolies

As noted above, the most significant attribute of the Canadian public health care system is that it establishes a government monopoly in each province for payment of insured health services. Both NAFTA Chapter Fifteen and the GATS set out requirements for the designation and maintenance of monopolies.[5]

Investment and Services

NAFTA Chapters Eleven and Twelve set out obligations respecting investment and cross-border trade in services. The health care system affects the delivery of services and the investments of firms that deliver those services.[6] The GATS also imposes obligations respecting trade in services.

Intellectual Property

Both NAFTA Chapter Seventeen and the *Agreement Respecting Trade-Related Aspects of Intellectual Property Rights* (TRIPS Agreement or TRIPS)[7] impose extensive requirements respecting intellectual property rights, including patents. Many prescription drugs are subject to patents. Both NAFTA Chapter Seventeen and the TRIPS Agreement impose restrictions on the extent to which the health care system can make use of cheaper generic drugs.

Subsidy Disciplines

The trade-in-goods provisions of the trade liberalizing agreements permit countervailing duties to be levied against imported goods that are subsidized and impose other disciplines on subsidization. Canada's health care system is based upon the payment of subsidies.

Monopolies

NAFTA Chapter Fifteen

NAFTA Article 1502 sets out the NAFTA obligations respecting monopolies. A "monopoly" is defined in NAFTA Article Fifteen as follows:

> "**monopoly** means an entity, including a consortium or government agency, that in any relevant market in the territory of a Party, is designated as the sole provider or purchaser of a good or service ..."

The public authority established by each province to pay for insured health services is clearly the sole provider of insurance services in respect of the insured health services because private insurers, either by law or as a practical matter, are excluded from that insurance market. Also, the public authority is arguably the sole purchaser of those services because no one, besides the public authority, is permitted to pay for them.

Article 1502(1) provides that nothing in NAFTA prevents the designation of a monopoly. Article 1502(2) sets out requirements that must be observed if a Party (including a provincial government) intends to designate a monopoly. Prior notice must be given to other NAFTA Parties and the Party must introduce conditions on the operation of the monopoly that will minimize or eliminate nullification and impairment of certain NAFTA provisions including NAFTA Chapter Twelve (Cross-Border Trade in Services) but not NAFTA Chapter Eleven (Investment). This provision is not relevant to existing provincial public authorities because these were designated many years ago. Article 1502(2) would be relevant if a province expanded the public component of its health care system by increasing the number of insured health services subject to the exclusive coverage of its health insurance plan. Of much greater relevance in these circumstances however is NAFTA Article 1110 (Expropriation and Compensation) discussed below.

NAFTA Article 1502(3) sets out a number of requirements that must be observed by a Party respecting any monopoly it designates. However, Article 1502(3) applies only to privately-owned monopolies and federal government monopolies. Provincial government monopolies are not subject to these requirements. While the *Canada Health Act* is a federal statute, it merely sets out certain requirements that must be satisfied for provinces to receive grants. The public authorities that pay for insured health services are clearly provincial and not federal.

Responses to Questions

These provisions respecting monopolies did not exist at the time that Canada's public health care system was established. They have minimal impact on the ability of provincial governments to maintain a public health care system and would not impede an expansion of the public component of the public health care system. However, NAFTA Article 1110 (Expropriation and Compensation) discussed below significantly affects the ability to expand the public component of Canada's health care system.

Monopolies Under the Gats

GATS Article VIII sets out requirements that Members must observe respecting their monopoly suppliers of services. As these obligations are closely tied to other GATS obligations, they will be described below.

Investment and Cross-Border Trade in Services – NAFTA Chapters Eleven and Twelve

The provisions of NAFTA Chapters Eleven (Investment) and Twelve (Cross-border Trade in Services) clearly have a potential impact on Canada's ability to maintain a public health care system. Subject to certain reservations described below, the obligations imposed by NAFTA Chapters Eleven and Twelve apply to provincial as well as to federal measures.

One important distinction between the obligations imposed by Chapter Eleven and those imposed by Chapter Twelve is that the investor/state procedures described below apply only to breaches of NAFTA Chapter Eleven and not to breaches of NAFTA Chapter Twelve.

Scope and Coverage

NAFTA Chapter Eleven covers measures relating to investors of the United States and Mexico and investments of those investors within Canada. The expression "investment" is broadly defined and includes a subsidiary of a U.S. or Mexican investor as well as a wide range of other property interests.

NAFTA Chapter Twelve applies to measures relating to the cross-border trade in services. Cross-border provision of services means the provision of a service from the United States or Mexico into Canada, in Canada by a Canadian national or firm to a person in the United States or Mexico, or by a U.S. or Mexican national in Canada.

Federal or provincial measures relating to a company in Canada owned by U.S. investors that provides services to consumers in Canada are covered by NAFTA Chapter Eleven and not by Chapter Twelve. Federal or provincial measures relating to a company in the United States providing services from the United States to consumers in Canada are covered by Chapter Twelve and not by Chapter Eleven.

Exceptions and Reservations

The obligations under Chapters Eleven and Twelve are general in their application but are subject to some general exceptions for particular sectors. However, none of these sectoral exceptions is relevant to the issues considered in this paper.[8]

Certain obligations under both NAFTA Chapters Eleven and Twelve are subject to two important categories of reservations. The first category is a reservation under NAFTA Annex I for provincial measures that grandfathers all such measures that were in effect when NAFTA entered into force on January 1, 1994. The second category is a sectoral reservation under NAFTA Annex II for social services that includes health. There are other significant obligations under Chapter Eleven that are not subject to any reservations.

This paper will first consider the Chapter Eleven and Chapter Twelve obligations that are subject to reservations, because the effect of the reservations is to significantly shield Canada's health care system from these obligations. The paper will then consider the obligations that are not subject to reservations and respecting which there is no shield for the health care system.

Obligations Under Chapters Eleven and Twelve Subject to Reservations

The obligations under NAFTA Chapters Eleven and Twelve that are subject to reservations are the following:

- National Treatment Obligations under Articles 1102 and 1202
- Most-Favoured-Nation Treatment Obligations under Articles 1103 and 1203
- Performance Requirements under Article 1106
- Senior Management and Boards of Directors under Article 1107
- Local Presence Requirements under Article 1205

Of the foregoing, the national treatment obligations under Articles 1102 and 1202 are by far the most important as regards potential effect on Canada's public health care system

National Treatment Obligations Under Articles 1102 and 1202

Articles 1102 and 1202

The combined effect of Article 1102(1) and (2) is to require that the federal government and each province accord to investors of the United States and Mexico and their investments treatment no less favourable than that it accords, in like circumstances, to its own investors and their investments with respect to the establishment, acquisition, expansion, management, conduct, operation, and sale or other disposition of investments. Article 1202(1) sets out a similarly worded obligation respecting cross-border service providers of the United States and Mexico.

NAFTA Article 1102(3) establishes a special rule when applying Article 1102(1) and 1102(2) to measures of provincial governments that requires that the province accord treatment no less favourable than the most favourable treatment accorded, in like circumstances, by that province to investors, and to investments of investors, of the Party (i.e. Canada) of which it forms a part. Article 1202(2) sets out a similar rule respecting cross-border services.

NAFTA Article 1102(4)(a) prohibits minimum equity requirements and Article 1102(4)(b) prohibits requiring an investor of another Party, by reason of its nationality, to sell or otherwise dispose of an investment.

De Jure and De Facto Violations

Under both GATT and WTO jurisprudence, a measure need not be overtly discriminatory to breach a non-discrimination obligation. A measure can be neutral on its face but can be found to have a discriminatory effect. This is referred to as *de facto* discrimination, as distinct from *de jure* discrimination, which refers to a situation where a measure is discriminatory on its face.

While the concept has existed for a long time under the GATT, findings of *de facto* discrimination have been made on a case by case basis, with few if any general principles to act as a guide as to whether *de facto* discrimination will be found in any particular circumstance.

The concept of *de facto* discrimination has been carried over into the Chapter Eleven jurisprudence, with even less clarity than exists under the GATT and WTO jurisprudence.

Treatment No Less Favourable

Articles 1102 and 1202 address situations in which U.S. or Mexican investors and their investments, or U.S. or Mexican cross-border service providers, are treated differently and less favourably than their Canadian counterparts. Case law respecting national treatment provisions under other trade agreements like GATT 1947, GATT 1994 and the GATS has equated "no less favourable treatment" with "equality of competitive opportunities".

The concept of "no less favourable treatment" has been complicated rather than clarified by NAFTA Chapter Eleven jurisprudence. The Chapter Eleven tribunal in *Pope & Talbot Inc. and The Government of Canada* (*Pope & Talbot*)[9] interpreted Articles 1102(1) and (2) as imposing a best-in-jurisdiction treatment obligation. Under this interpretation, if a single U.S. investment is treated less favourably than a single domestic investment, there is a potential *de facto* violation even if the measures do not discriminate on their face unless the circumstances are not "like". While the finding of the *Pope & Talbot* tribunal is arguably wrong and is not binding on other tribunals, it has established an unhelpful precedent.

In Like Circumstances

As noted above, the less favourable treatment must be accorded "in like circumstances" in order for there to be a violation. The meaning of "in like circumstances" under Articles 1102 and 1202 is as yet uncertain. Investors have argued in Chapter Eleven cases that investments in the same business sector are "in like circumstances' regardless of what other circumstances there may be. The *Pope & Talbot* Chapter Eleven tribunal rejected this view and adopted an expansive view of "in like circumstances" and found that any difference in treatment linked to a rational government policy not motivated by discrimination created a situation of unlike circumstances. However, the NAFTA Chapter Twenty panel in *In the Matter of Cross-Border Trucking Services* (*Trucking Services)*[10] considering Article 1202 interpreted "in like circumstances" narrowly, and treated it as an exception.

Application to Canada's Public Health Care System

The essential characteristic of Canada's public health care system is that a public authority in each province pays for all insured health services within that province, with the effect that private insurers are excluded from the business of insuring those services. This essential characteristic does not raise a national treatment issue. Canadian insurers are excluded to the same extent as U.S. or Mexican insurers, whether seeking to provide insurance services through Canadian subsidiaries (and therefore subject to Chapter Eleven) or on a cross-border basis (and therefore subject to NAFTA Chapter Twelve). NAFTA Article 1502(1) clearly permits both the federal government and provincial governments to establish and maintain monopolies and NAFTA Articles 1102 and 1202 cannot be interpreted so as to frustrate this right.

There is no inherent problem under Articles 1102 or 1202 with the requirement that insured health services be supplied at rates that are established by the provincial government, or that prevent suppliers of those services from contracting with patients for the price of those services. Canadian suppliers are subject to the same constraints.

Articles 1102 and 1202 are problematic to the extent that Canada's health care system treats Canadian firms more favourably than U.S. or Mexican firms. A measure that excludes or severely limits the extent to which a U.S. or Mexican firm can engage in an activity connected with the health care system, when compared to its Canadian counterparts, can cause a potential violation of Articles 1102 or 1202. This circumstance could arise with measures that exclude for-profit firms from certain activities and limit participation to non-profit firms. A U.S. owner of a for-profit firm could argue that limiting participation in the activity to non-profit firms has the effect of reserving the activity to Canadians because non-profit U.S. firms do not operate in Canada. Contrary arguments can be made that for-profit firms and non-profit firms are not "in like circumstances". However, the potential for a violation remains.

One Province Setting the Standard for Other Provinces

One question that arises respecting the NAFTA national treatment obligations as applied to provinces is the extent, if any, to which treatment by one province can set a standard of treatment that must be observed by other provinces. Suppose that one province departs from the principles of the *Canada Health Act* and permits private insurers, including U.S.-owned insurers, to pay for insured health services. Does this province, in permitting private insurers to carry on a business from which insurers were formerly excluded, set a new standard so that a breach of Article 1102 occurs because the other provinces do not permit private insurers to carry on that business? The answer is that it does not. When Articles 1102(1) and (2) are read together with Article 1102(3) it is clear that the comparison of the treatments accorded to U.S. vis à vis domestic insurers is the treatment by "that province", and not the treatment accorded by some other province. The province departing from the *Canada Health Act* principles would have to treat U.S. insurers no less favourably than domestic insurers. However, the treatment by the departing province would not constitute the treatment benchmark for any other province.

The Other Obligations Under Chapters Eleven and Twelve Subject to Reservations

Most-Favoured-Nation Treatment Obligations Under Articles 1103 and 1203

Articles 1103 and 1203 also impose no less favourable treatment requirements, but the obligation applies as regards U.S. or Mexican investors and their investments, or U.S. or Mexican cross-border service providers vis à vis each other or their counterparts from other countries. There does not appear to be any attribute of Canada's public health care system that necessitates treating one set of foreign investors or their investments or foreign service providers less favourably than another.

Performance Requirements Under Article 1106

Article 1106(1) prohibits a government from imposing or enforcing certain requirements in connection with the establishment, acquisition, expansion, management, conduct or operation of the Canadian investment of a U.S. or Mexican investor. One such requirement is "to purchase, use or accord a preference to goods produced or services provided in its territory, or to purchase goods or services from persons in its territory."[11] Subject to the reservations described below, a provincial government would trigger a breach of Article 1106 if it imposed on a U.S.-owned Canadian company providing health services a requirement that it purchase goods or services

within Canada. Article 1106(3) sets out similar but narrower obligations respecting conditions for receipt of advantages like subsidies.

Senior Management and Boards of Directors Under Article 1107

NAFTA Article 1107 prohibits measures that require that an investor of another Party appoint to senior management positions individuals of any particular nationality. This obligation has no impact on the ability of Canada to maintain its public health care system.

Local Presence Requirements Under Article 1205

Article 1205 prohibits the federal government or a province from requiring cross-border service providers to establish or maintain a representative office or any form of enterprise or to be resident in Canada or the province. While this requirement may affect certain health-related issues, it has no impact on the ability of Canada to maintain its public health care system.

NAFTA Annex I and Annex II Reservations

The foregoing obligations under NAFTA Chapters Eleven and Twelve are subject to reservations under NAFTA Annexes I and II.

NAFTA Annex I Reservations

NAFTA Articles 1108(1) and 1206(1) permitted each NAFTA Party to exempt from the application of NAFTA Articles 1102, 1103, 1106, 1107, 1202, 1203 and 1205 any non-conforming measure that existed on January 1, 1994. The exemption was claimed by listing the measures in the Party's Schedule in NAFTA Annex I. The schedules of the federal governments of the NAFTA Parties were prepared before NAFTA came into effect. The Canadian government did not list the *Canada Health Act* but the *Canada Health Act* is not "non-conforming".

Provinces were allowed until January 1, 1996 to list their non-conforming measures. While lists were prepared and exchanged, in the end provinces were allowed to claim the reservation for all non-conforming measures existing on January 1, 1994. Therefore, each and every measure of every province affecting the Canadian health care system that existed on January 1, 1994 is exempt from all of the obligations listed above.

The exemption applies to any renewal of such measures and to amendments to such measures that do not make them more non-conforming. However, if a non-conforming measure is repealed or made less non-conforming, it cannot subsequently be reinstated or made more non-conforming.

The Annex I reservation establishes a safe haven that shields all provincial measures implementing the Canadian health care system existing on January 1, 1994 that do not conform to the foregoing NAFTA provisions. However, the shield is static. While amendments to measures that do not make them more non-conforming are covered by the grandfathering, there is always room for debate as to the effect of the amendment. As time moves on and the system evolves and laws change, the safe haven afforded by Annex I becomes less secure.

Annex II Reservation

NAFTA Articles 1108(3) and 1206(3) permitted each NAFTA Party to exempt sectors from the application of the foregoing NAFTA articles by listing the sectors in its Schedule to NAFTA Annex II. Unlike the Annex I reservations, which do not permit future changes that increase non-conformity, Annex II reservations are absolute. As long as a new measure is covered by the reservation, the new measure can increase the degree of non-conformity with these NAFTA articles.

Canada listed a reservation for Social Services as follows:

> "Canada reserves the right to adopt or maintain any measure with respect to the provision of public law enforcement and correctional services, and the following services to the extent that they are social services established or maintained for a public purpose: income security or insurance, social security or insurance, social welfare, public education, public training, health and child care."

The United States and Mexico have taken similar reservations. The NAFTA Parties accept that the Annex II reservations apply to provincial and state as well as to federal measures.

While the Social Services reservation has not been tested, its plain wording is sufficiently broad to cover the purely public component of the health care system in each province, i.e., payment for insured health services by a provincial public authority. While the services covered are called "insured" health services, the fact is that they are paid for directly by the provincial governments or by direct reimbursement to the consumer of the services. Health services are "social services" and the "public purpose" is to ensure universal access to health care. However, how far the Annex II reservation extends beyond this is debatable. The Annex II reservation may cover the provision of health services exclusively by non-profit organizations but it is questionable whether the reservation covers a situation where health services are provided by for-profit entities or by a mix of for-profit and not-for-profit entities.[12]

Responses to Questions –
Obligations Under Chapters Eleven and Twelve Subject to Reservations

None of the obligations discussed above existed at the time that the Canadian public health care system was established. All of these obligations apply to provincial as well as to federal measures. The obligations under Chapter Eleven have the potential for greater impact than those under Chapter Twelve because of the availability to U.S. and Mexican investors of investor/state dispute procedures described below.

While not affecting the essential characteristics of the Canadian public health care system, the non-discrimination requirements of the national treatment obligations have potential impact on any aspect of the system that treats U.S. or Mexican firms less favourably than their Canadian counterparts. The other NAFTA obligations discussed above have much less potential impact. The potential impact of all of the obligations discussed above is reduced substantially by the Annex I and Annex II reservations. The Annex I reservations provide a safe haven but one that will erode over time as the system evolves. The Annex II reservation provides a complete shield from the impact of these measures on the purely public component of Canada's health care system.

Obligations Under Chapters Eleven and Twelve Not Subject to Reservations

The obligations under NAFTA Chapters Eleven and Twelve that are not subject to reservations are the following:

- Expropriation and Compensation under Article 1110
- Minimum Standard of Treatment under Article 1105
- Transfers under Article 1109
- Licensing and Certification under Article 1210

Of the foregoing, the obligation respecting expropriation and compensation under Articles 1110 is by far the most important.

Expropriation and Compensation Under Article 1110

Article 1110

NAFTA Article 1110(1) provides as follows:

> "No Party may directly or indirectly nationalize or expropriate an investment of an investor of another Party in its territory or take a measure tantamount to nationalization or expropriation of such an investment ("expropriation"), except:
>
> (a) for a public purpose;
> (b) on a non-discriminatory basis;
> (c) in accordance with due process of law and Article 1105(1); and
> (d) on payment of compensation in accordance with paragraphs 2 through 6."

Paragraphs 2 to 6 set out rules respecting the calculation of compensation.

NAFTA Article 1110 and Expropriation Under International Law

Article 1110 has the effect of codifying the international law standard respecting expropriation. Customary international law requires that states provide compensation to aliens for expropriated property. Several NAFTA Chapter Eleven tribunals have found that the concept of expropriation under Article 1110 is not more expansive than under international law. The notion of "tantamount" merely carries into NAFTA the concept of creeping expropriation in customary international law that occurs when a state does not take property outright but applies measures that have the same effect.

That being said, there are difficulties with Article 1110. The domestic law in both the United States and Canada recognizes that many actions taken by the state adversely affect property rights but should nonetheless not be treated as compensable. The power to regulate without having to compensate is sometimes referred to as the "police power". The police power exists under international law. However, unlike in the United States and Canada, where ample jurisprudence defining the police power exists, the notion of the police power is poorly developed in international law because most international jurisprudence, such as that of the Iran-

United States Claims Tribunal, has addressed expropriation in circumstances, such as events occurring during a revolution, where public interest regulation was not an issue.

Substantial interference with business interests has been held by international tribunals and by the NAFTA Chapter Eleven tribunal in *Metalclad Corp. v. The United Mexican States*[13] to constitute an expropriation. In the *Metalclad* case the interference obliterated the value of the investment. Unfortunately, the measure in question was an ecological decree with the result that *Metalclad* has been incorrectly characterized as an assault on environmental regulation.

Substantial interference could occur in the health care context in Canada if the public component of the system were expanded in a way that increased the exclusion of private firms. For example, suppose that the decision was taken to include all dental services as "insured health services" and not just those provided in hospitals. The effect would be that insurers providing dental coverage would be forced to exit that business. While the decision would have been taken to fulfil the public purpose of ensuring increased accessibility for those who could not afford dental coverage or dentist's fees, it is likely that a NAFTA Chapter Eleven tribunal would treat this as an expropriation and require the payment of compensation. The same applies to other health services such as home care.

Article 1110 does not prohibit expropriation. A provincial government may expropriate so long as the expropriation is for a public purpose (which expanding the public component of the health care system would clearly be), is non-discriminatory (which would apply because *all* private insurers are excluded), is in accordance with due process and Article 1105 (which would preclude statutory limits on rights to judicial relief), *and* provided that compensation is paid. The fact that Article 1110 does not prohibit expropriation but merely sets conditions upon it means that Article 1110 does not prevent the designation of a monopoly. This has a negative consequence because Article 1110 cannot be construed as being inconsistent with Article 1502(1), which permits the designation of a monopoly, because Article 1110 does not prevent the designation of a monopoly. However, Article 1110 can make the designation of a monopoly much more expensive if private firms, excluded from businesses that they formerly carried on, have to be compensated.

Other Obligations Under Chapters Eleven and Twelve Not Subject to Reservations

Minimum Standard of Treatment Under Article 1105

NAFTA Article 1105(1) is entitled **Minimum Standard of Treatment** and reads as follows:

> "Each Party shall accord to investments of investors of another Party treatment in accordance with international law, including fair and equitable treatment and full protection and security."

This NAFTA provision has created considerable interpretative difficulties. On July 31, 2001, the NAFTA Free Trade Commission (NAFTA Commission) adopted an agreed interpretation that interpreted Article 1105 as applying the minimum standard of treatment under international law and that the references to "fair and equitable treatment" and "full protection and security" did not expand upon this standard. NAFTA Article 1131(2) provides that agreed interpretations are binding on Chapter Eleven tribunals.[14]

The minimum standard of treatment under international law is an elusive concept with imprecise meaning. However, Article 1105(1) is not likely to have any impact on the Canadian health care system as presently structured. A breach of Article 1105(1) could be triggered if a decision were taken to extend the public component of the system, such as through the establishment of a compulsory national home care program, and affected private firms were expressly denied legal recourse through a privative clause. A denial of access to the court system could constitute a denial of justice, which would constitute a breach of the minimum international law standard.

Transfers Under Article 1109

Article 1109 prohibits restrictions on repatriation of profits, dividends, and various other payments. Article 1109 has no impact whatsoever on Canada's ability to maintain its public health care system.

Licensing and Certification Under Article 1210

Article 1210 sets out certain requirements respecting the licensing of nationals of other NAFTA countries. While the professional service providers referred to in Article 1210 include health care professionals, Article 1210 has no impact on Canada's ability to maintain its public health care system.

Responses to Questions –
Obligations Under Chapters Eleven and Twelve Not Subject to Reservations

The obligations imposed by Article 1110 and 1105 have the effect of codifying international law standards that existed at the time that Canada's public health care system was established. However, they have far greater impact now because of the NAFTA investor/state procedures described below. Under international law, an investor whose property in another country had been expropriated would have to convince its government to commence proceedings in the International Court of Justice. The proceedings could take many years and would not necessarily ever result in a payment of compensation to the investor. Under NAFTA, an investor whose property in another NAFTA country is expropriated can commence a Chapter Eleven proceeding against the federal government of the NAFTA country where the expropriation took place, without the permission or involvement of its own government, and receive compensation.

The obligations imposed by Articles 1109 and 1210 did not exist at the time Canada's public health care system was established but have no impact upon it. The obligations imposed by Articles 1110, 1105, 1109 and 1210 apply to provincial as well as federal measures.

Article 1110 should have no impact on Canada's public health care system as presently constituted but would have a major impact if the public component of the system were expanded in any way that adversely affects the businesses of private firms. Article 1110 does not prevent the expansion of the system but could make it very expensive.

Similarly Article 1105 should have no impact on Canada's public health care system as presently constituted. However, Article 1105 would affect any expansion of the public component of the system that is coupled with a denial of recourse to the courts by private firms.

GATS and Trade in Services

The GATS applies to measures of Members affecting trade in services.

Services Supplied in the Exercise of Governmental Authority

The expression "services" is broadly defined in the GATS and includes any service in any sector except services supplied in the exercise of governmental authority. GATS Article I:3(c) provides a "service supplied in the exercise of governmental authority" means any "service which is supplied neither on a commercial basis nor in competition with one or more service suppliers". This definition applies to the purely public component of the Canadian health care system, i.e., the payment under provincial health insurance plans for "insured health services". Under each provincial plan, the government is acting as an insurer but such "insurance" services are not supplied on a commercial basis because no premiums are charged or any premiums that are charged are unrelated to risk. The government does not compete with private insurers because private insurers, either by law or as a practical matter, are excluded from this market. The extent to which the GATS carve-out for services supplied in the exercise of governmental authority extends beyond the situation where the government itself is providing the service is debatable. For example, Sinclair and Grieshaber-Otto (2002 at page 20) rightly question how the carve-out would be applied to situations involving a mix of governmental, private for-profit and private not-for-profit delivery.[15]

Modes of Supply

Using the United States and a U.S. service supplier as an example, the GATS applies to services supplied by the U.S. supplier from the United States into Canada, in the United States by the U.S. supplier to a Canadian service consumer, by the U.S. supplier through a commercial presence in Canada such as a subsidiary corporation, and by the U.S. supplier through the presence of a U.S. national in Canada. The scope of the GATS is broader than NAFTA Chapter Twelve because it covers provision of services from within Canada by a subsidiary of the U.S. service supplier, as well as the cross-border provision of services. However, NAFTA Chapter Eleven would cover this situation.

Significant GATS Obligations

Schedule of Commitments

Each GATS Member, including Canada, completed a Schedule of Commitments in which the Member identified the service sectors respecting which it was willing to undertake commitments. Each schedule identifies the sector and lists limitations on market access and national treatment that the Member wishes to retain in respect of that sector. Canada has included in its list of sectors "Life, accident and health insurance services" [emphasis added][16] Canada lists a number of market access and national treatment limitations respecting this sector but the limitations do not refer to provincial health insurance plans. Canada has not listed other services relating directly to health care.[17] Some commentators have pointed out that hospital support services such as food, laundry or janitorial services may be covered by GATS obligations. However, inclusion of services such as these should have virtually no impact on Canada's ability to maintain its public health care system.

Market Access and National Treatment

GATS Article XVI requires that each Member accord service suppliers of other Members, through the modes of supply described above, treatment no less favourable than as specified in its Schedule of Commitments. Article XVI also prohibits (unless specified in the Schedule) certain limitations such as limitations on the number of service suppliers or on the value of services or service operations or numbers of natural persons employed or form of legal entity or participation of foreign capital. However, these prohibitions do not include price controls or government established tariffs of fees for services such as are required by the *Canada Health Act* with respect to insured health services.

Subject to the limitations specified in the Schedule of Commitments, GATS Article XVII requires in respect of each sector listed in the Schedule of Commitments that each Member shall accord to services and service suppliers of any other Member respecting measures affecting the supply of services treatment no less favourable than it accords to its own like services and service suppliers. This means that the Canadian subsidiary of a U.S. owned insurance company providing health insurance must be treated no less favourably than its Canadian-owned counterpart.

Most-Favoured-Nation Treatment

GATS Article II requires in respect of measures covered by the GATS that each Member accord, immediately and unconditionally, to services and service suppliers of any other Member, treatment no less favourable than it accords to like services and service suppliers of any other country. Members were permitted to list exemptions but none of the exemptions listed by Canada applies to health care.

As with the most-favoured-nation obligations under NAFTA Articles 1103 and 1203, this obligation has minimum effect on Canada's public health care system, as the measures essential to its continuance do not depend on according more favourable treatment to services and services suppliers of one country as compared to suppliers of other countries.

Monopolies

The GATS clearly permits the establishment of monopolies because GATS Article VIII:1 requires each Member to ensure that a monopoly supplier of a service act consistently with the Member's obligations under Article II (most-favoured-nation) and its specific commitments. As well, GATS Article VIII:2 provides that a Member must ensure that a monopoly supplier does not abuse its non-monopoly position in services outside the scope of the monopoly that are covered by specific commitments. A provincial health insurance plan could not unfairly compete with private foreign-owned insurers in the health insurance market for services outside the scope of "insured health services". This GATS provision should not create difficulties because provincial health insurance plans (which pay for insured health services but not for non-insured services) do not compete with private health insurers because they service different markets.

Canada could expand the monopoly rights of the provincial insurance plans by expanding the range of insured health services to include services such as home care. However, since Canada has made a specific commitment respecting health insurance, the government of Canada would have to negotiate a compensatory adjustment with any other affected Member. The

compensatory adjustment would take the form of liberalizing commitments in other service sectors and should *not* be confused with compensation of the sort required under NAFTA Article 1110(1) for expropriation. How onerous this exercise would be would depend on the extent to which private sector entities were displaced from the market by reason of the expansion of the monopoly. Absent such entities with real economic interest, the obligation to compensate is a purely theoretical concern.

Responses to Questions

The GATS is an entirely new agreement that came into existence on January 1, 1995 and did not exist when Canada's public health care system was established. Provincial as well as federal measures are covered.

The exclusion of "service supplied in the exercise of governmental authority" from the services covered by the GATS is significant because such exclusion covers the activities of the provincial health insurance plans in paying for "insured health services". The impact of the GATS is also muted by the fact that the GATS clearly permits monopoly service suppliers. To the extent, if any, that the health insurance plans are not excluded by the "government authority" carve-out, the provincial plans would be subject to the monopoly requirements but clearly permitted. It is unlikely that any provincial health care plan would have an interest in competing, fairly or unfairly, in the private insurance market.

The market access and national treatment provisions impose obligations with respect to any health service respecting which Canada assumes commitments. So far, the commitments respecting direct delivery of health services (as distinct from health insurance) are minimal or non-existent. This could change in subsequent negotiating rounds. Canada should carefully assess the impact on the health care system of each and every health-related commitment it undertakes in future negotiations.

Other Provisions of the Trade Liberalizing Agreements with Some Potential Impacts

As noted above, there are other provisions of the trade-liberalizing agreements that have some potential impact on the health care system.

Intellectual Property

Substantive Obligations

Both the TRIPS Agreement and NAFTA Seventeen set out extensive obligations respecting intellectual property rights, including patents. The TRIPS Agreement establishes a minimum term of protection of twenty years from the date of filing a patent application. Patent owners must be able to prevent third parties from making, using, offering for sale, selling or importing the patented product during the term of protection. Compulsory licensing, while permitted under limited circumstances, has been significantly curtailed.

Some flexibility is provided through limited exception provisions. In *Canada – Patent Protection for Pharmaceutical Products,*[18] a WTO panel upheld a provision of Canada's patent legislation challenged by the E.U. that permits generic drug producers to make patented drugs for the purposes of testing the generic version before the patent has expired that is of critical importance to Canada's generic drug industry.[19]

Responses to Questions

The intellectual property obligations under the TRIPS Agreement and NAFTA Chapter Seventeen did not exist at the time that Canada's public health care system was established. The intellectual property conventions in existence at the time, such as the *Paris Convention for the Protection of Industrial Property*[20] did not impose hard obligations respecting patents such as exist under the TRIPS Agreement and NAFTA Chapter Seventeen.

The question of application to provincial governments is irrelevant because the matters covered by the TRIPS Agreement and NAFTA Chapter Seventeen, unlike most aspects of the health care system, fall within exclusive areas of federal jurisdiction.

The TRIPS Agreement and NAFTA Chapter Seventeen have no direct impact on Canada's ability to maintain a public health care system. However, the obligations imposed by these agreements have an indirect impact to the extent that drug prices are affected through the patent rights enjoyed by brand drug producers and through the limitations placed on compulsory licensing.

Subsidies

Substantive Provisions

GATT 1994 and the *Agreement on Subsidies and Countervailing Measures* (SCM Agreement)[21] impose disciplines respecting the granting of subsidies, and permit Member countries to impose countervailing duties to offset the effect of subsidized imports that cause

material injury to domestic industries. The Canadian health care system provides a significant advantage to companies with unionized work forces (such as automotive assemblers) in Canada because those companies do not have to provide health benefits that are a part of the collective agreements of their counterparts in the United States. If public health care is a "subsidy" under the SCM Agreement, it is unequivocally widely available and not "specific" within the meaning of the SCM Agreement. Countervailing duties may only be imposed against subsidies that are "specific" as described in the SCM Agreement. Furthermore, subsidies that are not specific are "non-actionable" under the SCM Agreement and are not subject to any of the proceedings that may be taken against "actionable" subsidies.

Export subsidies, and subsidies that are contingent upon the use of domestic over imported goods, are prohibited under the SCM Agreement. While the export subsidy prohibition is irrelevant to Canada's public health care system, any government measure under the health care system that favoured local over imported goods would be a prohibited subsidy under the SCM Agreement.

Responses to Questions

While the provisions in GATT 1994 respecting countervailing duties existed at the time that Canada's public health care was established, the SCM Agreement only came into existence in 1995, replacing an earlier Tokyo Round subsidies code. The SCM Agreement is significant to the public health care system in the positive sense that it sets out a definition of subsidy and defines the circumstances in which subsidies are actionable, whether through the application of countervailing duties or by invoking dispute settlement procedures. It is clear that if Canada's public health care system constitutes a subsidy at all, it is non-actionable because it non-specific. The provisions in the SCM Agreement respecting prohibited subsidies are unlikely to be violated by any measure adopted respecting Canada's health care system.

Provisions of Trade Agreements with Minimal Effect

The trade liberalizing agreements contain many other provisions not discussed above but these should have minimal impact on Canada's ability to maintain its public health care system.

Trade in Goods

GATT 1994 imposes obligations respecting trade in goods that include most-favoured-nation and national treatment obligations, obligations respecting tariff bindings and prohibitions of quotas and other forms of import and export restrictions. Obligations under GATT 1994 are subject to a number of exceptions, including exceptions relating to health and conservation issues that have been the subject of extensive jurisprudence and upon which there are conflicting views.

NAFTA Chapter Three also sets out obligations respecting trade in goods. NAFTA Chapter Three provides for the elimination of tariffs and imposes certain other obligations. However, the obligations imposed by NAFTA Chapter Three are largely based on incorporated provisions of GATT 1994, including the GATT 1994 exceptions. NAFTA Chapter Three imposes some conditions on export restrictions in addition to the requirements of GATT 1994.

GATT 1994 carries forward the obligations set out in GATT 1947 and these existed at the time that Canada's public health care system was established. The trade-in-goods provisions in NAFTA did not exist at the time that Canada's public health care system was established except to the extent that they consisted of incorporated GATT provisions. Both sets of obligations apply to provincial as well as federal measures. While the trade in goods provisions in GATT 1994 and NAFTA may have an impact on health issues, such as the ability to protect health or the environment through trade restrictive measures, these obligations have virtually no impact on Canada's ability to maintain its public health care system.

Standards

NAFTA Chapter Nine imposes obligations affecting the establishment of standards respecting both goods and services, and Section B of NAFTA Chapter Seven establishes obligations respecting sanitary and phytosanitary (SPS) measures. These provisions have counterparts in the WTO Agreement. The *Agreement on Technical Barriers to Trade* (TBT Agreement) [22] imposes obligations respecting technical regulations, standards and conformity assessment procedures. The *Agreement on Sanitary and Phytosanitary Measures* (SPS Agreement), [23] imposes obligations respecting SPS measures similar to those in NAFTA Chapter Seven.

SPS measures include a variety of measures such as measures respecting contaminants in food and pest control that certainly have an impact on human health. Both the SPS Agreement and NAFTA Chapter Seven require a scientific basis for measures and impose least-trade restrictive requirements that are of considerable concern to non-governmental organizations (NGOs) concerned with issues such as genetically modified foods.

The SPS Agreement, the TBT Agreement and the NAFTA obligations respecting standards all came into effect after Canada's public health care system had been established. There was an earlier Tokyo Round agreement on technical barriers to trade, but Canada's public health care system had been largely if not entirely established before it took effect.

NAFTA Chapter Nine contains only a best-efforts provision as regards compliance by provincial governments. However, subject to a few exceptions, Section B of NAFTA Chapter Seven is subject to the provision in NAFTA Article 105 respecting observance by provincial governments. For the most part, the SPS Agreement and the TBT Agreement apply to measures of regional (i.e., provincial) governments as well as to measures of national governments.

The obligations respecting standards imposed by these agreements clearly have an effect on health-related issues, such as measures respecting contaminants in food, or those that prohibit or prescribe strict rules for handling hazardous materials. However, these obligations have no impact on Canada's ability to maintain its public health care system.

Government Procurement

The *Agreement on Government Procurement* (GPA)[24] and NAFTA Chapter Ten impose certain obligations respecting government procurement by certain federal government departments and entities. No obligations are imposed at the provincial level. The obligations imposed at the federal level have no effect on Canada's ability to maintain its public health care system. Canada was subject to an earlier and less comprehensive Tokyo Round government procurement agreement. However, Canada's public health care system had been largely established at the time that the earlier agreement came into existence.

If payment for insured services by provincial public authorities does constitute "government procurement", this critical feature of the Canadian public health care system would not be subject to GPA or NAFTA obligations, and would be exempt from certain provisions under NAFTA Chapters Eleven and Twelve. However, government procurement for these purposes would likely be interpreted as meaning procurement for consumption by the government. While insured health services are paid for by provincial public authorities, they are consumed by patients.

Dispute Resolution

The impact of the trade liberalizing agreements on the ability of Canadian governments to maintain a public health care system is affected by the method of dispute resolution under these agreements because dispute resolution procedures in a trade agreement provide the means for challenging non-conforming measures. The more effective the procedures, the greater the potential impact of a successful challenge.

WTO Agreement

Understanding on Rules and Procedures Governing the Settlement of Disputes (DSU)

Disputes under the WTO Agreement are resolved through the dispute settlement procedures set out in the *Understanding on Rules and Procedures Governing the Settlement of Disputes* (DSU).[25] These are purely state-to-state proceedings. The complaining Member country or countries, and the Member country against which the complaint is made, are the principal parties in these proceedings. Other Member countries have limited rights as third parties. No other entity (including provincial governments, non-governmental organizations or private firms) has any standing in these proceedings. Disputes are heard by ad hoc panels of three, chosen by the Director General of the WTO in consultation with the parties. Panel decisions may be appealed to a standing Appellate Body. Panel and Appellate Body decisions are adopted by the Dispute Settlement Body (DSB) established under the DSU. Unlike under GATT 1947, the Member country whose measures have been found inconsistent with WTO obligations cannot block adoption of the report. Once the report is adopted, the Member country whose measures have been found to be inconsistent with WTO obligations has a "reasonable period of time" within which to comply, which can be fixed by arbitration. The DSU permits compensation in lieu of bringing measures into conformity with WTO obligations in limited circumstances. The DSU sets out procedures for determining whether a Member has complied with DSB requirements. If a Member does not comply, the complaining Member can retaliate by withdrawing WTO concessions, but must do so only in accordance with the procedures set out in the DSU. The practical effect of the DSU is that a Member whose measures have been found to be inconsistent with WTO requirements has the option of accepting retaliation in lieu of complying.

Interpretation

WTO agreements are interpreted in accordance with the rules of the *Vienna Convention on the Law of Treaties* (VCLT). The principal rule of interpretation is set out in Article 31 which provides that a "treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose". The approach that has been taken by the Appellate Body is strongly textual, with context and object and purpose generally being used to support an interpretation based on text, rather than as an excuse for ignoring the text or reading an improbable meaning into the text. The Appellate Body tends to favour market-based solutions, but has expressed support for the ability of Members to adopt certain public interest measures, such as those protecting the environment.[26] However, if faced with a case involving Canada's health care system, it is unlikely that the Appellate Body would be influenced at all by the fact that many Canadians regard the public health care system as a defining national characteristic.

The burden of proof is upon the complaining party to establish a *prima facie* case of violation. The burden then shifts to the other party to establish that a violation has not occurred. The reverse applies with exceptions, with the burden falling on the party claiming the benefit of the exception to establish that the exception applies. Exceptions tend to be construed narrowly.

Jurisprudence

WTO jurisprudence is extensive and reasonably consistent, which is the result of panels being assisted in their deliberations by the staff of the WTO Secretariat and of the standing Appellate Body.

NAFTA

NAFTA Chapter Twenty – State-to-State

NAFTA Chapter Twenty provides for state-to-state dispute resolution respecting virtually all provisions of NAFTA.[27] The NAFTA Chapter Twenty provisions are similar in basic concept to those in the DSU but there are differences in detail. Panels, which are ad hoc, are comprised of five members with a reverse selection process (i.e. a disputing Party selects citizens of the other or another disputing Party rather than its own citizens). Panel decisions are final with no appeal. Compensation is an option in lieu of implementation, and the complaining Party may suspend NAFTA benefits. Unlike the DSU, which requires review of retaliatory measures before they are imposed, NAFTA Chapter Twenty only provides for review after imposition. As under the DSU, only federal governments have standing.

Subject to a few exceptions, a NAFTA Party with a complaint respecting measures of another Party can choose between NAFTA and the WTO Agreement. A Party will invariably choose the dispute resolution process under the agreement which is most favourable to its case.[28]

NAFTA Chapter Eleven – Investor/State

NAFTA Chapter Eleven makes provision for investor/state dispute settlement procedures that are in addition to, and not in lieu of, the procedures of NAFTA Chapter Twenty. These provisions permit an investor of a Party who has incurred loss or damage, by reason of a breach by another Party of an obligation of Chapter Eleven,[29] to initiate arbitral proceedings against the federal government of the Party committing the breach, the end result of which can be an award of monetary damages payable by the federal government.[30] Proceedings can involve provincial measures but the federal government is liable for the damages. Provincial governments have no standing in the proceedings. An investor can also initiate arbitral proceedings on behalf of an enterprise that it controls of the Party committing the breach (e.g. a U.S. investor commencing proceedings against Canada on behalf of its Canadian subsidiary) that has incurred damage as the result of a breach. The investor may choose between the United Nations Commission on International Trade Law (UNCITRAL) Arbitration Rules and the Additional Facility Rules of the International Centre for the Settlement of Investment Disputes (ICSID).[31] Cases are decided by tribunals of three members, one being chosen by the investor, one being chosen by the Party complained against and the third (presiding member) being chosen by agreement or by the ICSID Secretary. NAFTA Chapter Eleven does not provide for appeal but does not preclude judicial review in the domestic court system.

Interpretation

Like the WTO agreements, NAFTA is interpreted in accordance with the VCLT. However, NAFTA Article 102 sets out expansive objectives that have been characterized, both by Chapter Twenty panels and Chapter Eleven tribunals, as "trade liberalizing". Panels and tribunals have sometimes used Article 102 as a means for arriving at a more "trade liberalizing" resolution of a dispute than is justified by the text.

The approach to burden-of-proof is similar to that under the DSU, and exceptions tend to be construed narrowly. However, in investor/state proceedings under NAFTA Chapter Eleven, there is a special rule for determining the applicability of the reservations in the NAFTA Annexes.

The NAFTA Party asserting the reservation as a defence may request an interpretation from the NAFTA Commission as to whether the reservation applies. This means that, if Canada asserted that the Social Services reservation in Annex II provided a defence, Canada could request an interpretation from the NAFTA Commission that, if issued within 60 days of the request, would be binding on the tribunal. The position that a U.S. member of the NAFTA Commission would adopt in such a circumstance is difficult to predict. A number of commentators have noted that statements made by the United States Trade Representative shortly after NAFTA was signed indicate a view of the Social Services reservation that was much narrower than the Canadian view at the time. However, the positions of all three NAFTA governments since then have hardened against NAFTA Chapter Eleven and all three NAFTA Parties have tended to support each other's positions, including the Party whose investor is making a claim.

Jurisprudence

Such NAFTA jurisprudence as there is has a decidedly *ad hoc* quality to it and the quality of both Chapter Twenty and Chapter Eleven decisions has been mixed. While there is a NAFTA Secretariat, it is skeletal and Chapter Twenty panels and Chapter Eleven tribunals function pretty much on their own. As noted above, unlike under the DSU, there is no standing Appellate Body. To date, there have only been three Chapter Twenty panel decisions so it is difficult to predict how a panel might react in any given situation. There have been more Chapter Eleven tribunal decisions. While some themes are developing, the Chapter Eleven tribunal decisions are uneven and, as with Chapter Twenty, it is difficult to predict how a tribunal might choose to decide a matter before it.

Responses to Questions

The dispute settlement procedures established by DSU did not exist when Canada's public health care system was established. These procedures are much more effective than those that existed under GATT 1947. The country losing a case can no longer block the adoption of a report, as was the case under GATT 1947. NAFTA Chapter Twenty also provides for reasonably effective dispute settlement procedures.

The investor/state procedures established by NAFTA Chapter Eleven represent a real departure from the past, in that control over whether to initiate a claim rests with an investor and not with a government.

The existence of effective dispute settlement procedures heightens the impact of these trade-liberalizing agreements. While they clearly do not have the status of domestic law, non-compliance has more immediate consequences than was the case under the structure of international agreements that existed at the time that Canada's public health care system was established.

That being said, the trade liberalizing agreements do not have the same status as a constitution. Neither the federal government nor a province is required to change any measure just because a WTO or NAFTA Chapter Twenty panel or a NAFTA Chapter Twenty tribunal finds a breach. Retaliation under the DSU or NAFTA Chapter Twenty must be proportional to the economic interests affected,[32] and will not have a significant impact unless the economic interests affected are substantial. While the consequences of a Chapter Eleven damages award are more immediate, the economic interests affected must be considerable for a damages award to be a real matter for concern.

It should also be kept in mind that it is not easy for private interests to convince a government to initiate dispute settlement proceedings. Government agendas do not correspond to private sector agendas and all governments, including the U.S. government, have limited capability of pursuing dispute resolution claims.

While an investor does not have to seek the concurrence of its government to initiate a NAFTA Chapter Eleven claim, these claims are exceedingly expensive to pursue through to a successful conclusion. While serving a Notice of Intent to Submit a Claim is easy enough, a proceeding may go through multiple phases and entail several hearings with arbitrators who charge high hourly rates. The amount of money involved must be considerable to make this worthwhile.

Conclusion

The trade liberalizing agreements described in this paper have established a comprehensive set of norms with which federal and most provincial laws must conform. These norms limit the measures that can be adopted by governments to protect the public interest. Most of these norms did not exist at the time that Canada's public health care system was established. Some norms that did exist, such as the obligation under customary international law to provide compensation in the event of expropriation, have become much more significant because of the establishment, under the trade liberalizing agreements, of effective means of dispute resolution that did not previously exist.

Negative Potential Impact

Expropriation and Compensation

The single provision in all the trade liberalizing agreements that has the most negative potential impact on Canada's public health care is NAFTA Article 1110 (Expropriation and Compensation). If this provision and the accompanying investor/state dispute settlement procedures had existed in the 1960s, the public health care system in its present form would never have come into existence. While NAFTA Article 1110 does not affect the public health care system in its present form, the requirement to compensate, enforceable through investor/state procedures, makes expansion of the public component of the system impracticable. NAFTA Article 1110 also makes reduction of the public component of the system a one-way street. Once private firms acquire economic interests as the result of deregulation, returning to the *status quo ante* is possible only upon payment of compensation.

National Treatment and Market Access

The next most significant provisions with potential negative impact on Canada's public health care system are the national treatment and market access requirements under NAFTA and the GATS. To the extent that these obligations apply, they preclude treating foreign service providers (either within Canada or cross-border) less favourably than their Canadian-owned counterparts. While the core of Canada's public health care system, namely the payment by provincial health insurance plans of insured health services, may not be affected by these provisions, these provisions certainly affect ancillary aspects, notably such aspects as may favour non-profit over for-profit suppliers.

Canada's public health care system is largely shielded from these NAFTA obligations by the NAFTA Annex I grandfathering reservation and the Annex II Social Services reservation. However, the Annex I reservation is a one-way street and will erode over time. The Annex II Social Services reservation certainly covers the purely public component of the health care system, but it probably does not apply to aspects of the health care system outside the public component.

Positive Potential Impact

The potential impact of the trade liberalizing agreements is not wholly negative. Most provisions have little or no effect and several provisions of the trade liberalizing agreements clearly have a positive impact on Canada's ability to maintain a public health care system.

Monopolies

Notwithstanding the market bias of these agreements, both NAFTA and the GATS contain clear statements that Parties/Member countries may designate and maintain monopolies. The obligations imposed by these provisions are not onerous, particularly regarding provincial monopolies. The only caveat is that the ability to expand existing monopolies is, for all practical purposes, limited by the obligation to compensate in the event of an expropriation.

Subsidy Definition

The clear definition of subsidies in the SCM Agreement removes once and for all any doubt that Canada's public health care system constitutes a countervailable subsidy. U.S. countervailing duty law historically provided that non-specific subsidies were not countervailable, but the substance and application of U.S. countervailing duty law has been notoriously subject to manipulation by special interest groups, and there were no rules under GATT 1947 as to what constituted a countervailable subsidy. Potential U.S. countervail of Canada's health care system was a major concern at the time that Canada and the United States negotiated the CUFTA. The SCM Agreement has eliminated that issue as a concern once and for all.

Challenges

The trade liberalizing agreements present more challenges than opportunities. The opportunities afforded by these agreements for Canadians are created by the trade liberalization that takes place in other countries, not within Canada. Trade liberalization in the provision of health care products and services in other countries may present opportunities to Canadian entrepreneurs in those lines of business, as well as to Canadian private insurance companies looking for foreign markets into which to expand. However, the regulation of Canada's health care system is a domestic matter, and the international trading system, as modified by the trade liberalizing agreements, does present some challenges.

Increased Public Component as a Potential Expropriation

As indicated above, any decision to expand the public component of the health care system (i.e. insured health services being paid for solely by provincial insurance plans) will face the challenge of establishing that the expansion is not an expropriation.

Increased Private Component a One-Way Street

There is considerable pressure on provincial governments to reduce the public component of the health care system, i.e., reduce the number of insured health services that must be paid for through a provincial plan. Any provincial government that responds to these pressures should carefully consider the impact of any such reduction, because returning to the public *status quo ante* could be difficult and expensive.

Shared Private and Public Components

There is also pressure on provincial governments to open up the public component of the health care system by allowing patients to arrange their own coverage for insured health services. Under this model, provincial health insurance plans would pay for insured health services for some people while other people would arrange for coverage through private insurers of these same services. Both NAFTA and the GATS clearly permit governments to designate and maintain monopolies. Shared responsibility presents a more complex situation. Decisions of this sort will be presented with the challenge of how to structure the sharing of responsibility without breaching rules respecting public sector providers competing with private sector providers.

Maintaining the NAFTA Annex I Shield

A provincial government runs the risk of eroding the shield to NAFTA challenges afforded by the Annex I grandfathering provision each time it amends the measures that implement its health care system. The challenge with amendments is to balance the need for the health care system to be dynamic and change as circumstances change, and yet maintain the benefit of the Annex I reservation. As part of the process of amending provincial measures related to the health care system, provincial authorities should carefully consider the impact of the amendment on its Annex I safe haven.

What is the Real Risk of Claims and Challenges?

While it is easy enough to construct hypothetical worst-case scenarios under various provisions of the trade liberalizing agreements, assessing their real potential impact must be tempered with a touch of realism. Consider the matter of expropriation, which is the biggest single impediment to the expansion of the public component of the system. The risk of expropriation claims is proportional to the extent to which private interests are engaged in the affected activity. For example, private insurers in Canada are actively engaged in providing dental insurance. If all dental services were designated as insured health services covered exclusively by provincial plans, these insurers would be excluded and NAFTA Chapter Eleven compensation claims would be likely. However, the situation with home care services may be quite different. If private insurers are minimally involved in providing coverage for these services, or if such coverage that is provided is not profitable, the risk of claims is low. A risk analysis may disclose that the danger of a challenge or a claim to an expansion of the public health care system under a trade liberalizing agreement is both limited and manageable.

One dilemma that will be faced in any effort to expand the public component of the health care system is whether or not to include a privative clause in the implementing legislation that forecloses or limits access to the domestic courts. If a privative clause is not included in the implementing legislation, the government enacting the legislation runs the risk of claims from affected private parties in domestic courts. If a privative clause is included, the domestic risk is contained, but the risk of a NAFTA Chapter Eleven claim based on a denial of justice under Article 1105 is substantially increased. Legislators must weigh these risks by assessing what claims might be asserted and the relative chances under domestic law and NAFTA law of successfully resisting or containing them.

Options

While presenting challenges, the trade liberalizing agreements also leave ample options to governments as to the manner in which Canada's health care system is organized. While expanding the public component of the system is problematic, the trade liberalizing agreements have virtually no impact on the option of maintaining the public component of the health care system at its current level.

The trade liberalizing agreements also allow governments substantial freedom to regulate so long as they are not exclusionary or discriminatory. Most of the potential negative impact of the trade liberalizing agreements would arise through excluding private business interests from businesses that have previously been open to them or by discriminating against certain providers of services (such as, for example, for-profit U.S. owned providers in favour of non-profit Canadian owned providers). The trade liberalizing agreements leave wide latitude to governments to regulate the terms upon which services are delivered, including the prices payable for the services. As long as such regulations do not fall within the performance requirements prohibited by NAFTA Article 1106 (which are aimed at discriminatory treatment), governments retain a broad power to regulate. The trade liberalizing agreements also leave wide latitude on the ability of governments to regulate the prices of goods. While the intellectual property agreements impose some limits on the extent to which less expensive generic drugs can be used, governments are free to regulate the price of all drugs, including those subject to patents.

The Current Trade Negotiations – Challenges and Opportunities

The WTO Agreement and the Doha Round

The WTO Agreement, like GATT 1947 before it, is dynamic in that the members periodically participate in major negotiating rounds, the objective of which is to further liberalize trade. As mentioned above, a new round (the Doha Round) is currently underway. From the perspective of maintaining Canada's public health care system, Canadian negotiators face the challenge of resisting assuming obligations that could erode the ability of the federal and provincial governments to maintain the system. The most significant set of negotiations from this perspective will be the negotiation of further specific commitments under the GATS. Canadian businesses in the health care field will seek to increase their ability to expand into foreign markets through other Member countries, assuming increased commitments in these sectors. There will be corresponding pressure on Canada to assume similar commitments. The challenge to Canada's negotiators will be to balance the desire of certain Canadian businesses to secure market access in other countries with a need to ensure that the options open to Canadian governments as regards domestic health care are not eroded.

One significant opportunity presented by the new WTO round arises from the heightened concern expressed at Doha with social issues, and the ability of countries to address social problems. While the focus will be on the difficulties faced by developing countries, the issues should be the concern of all Member countries. There should be opportunities to advocate provisions in the WTO Agreement that assist Members in, rather than impeding them from, reducing health care costs.

NAFTA and the FTAA

Unlike the WTO Agreement, NAFTA is static. There has been one agreed interpretation under Chapter Eleven and there have been some technical changes to certain trade-in-goods provisions. NAFTA Working Groups meet regularly on a variety of issues, but these usually involve application. With a few minor exceptions, NAFTA does not contain any formal process for periodic negotiations for increased trade liberalization. However, the three NAFTA Parties and thirty-one other Western Hemisphere countries are currently negotiating a *Free Trade Agreement of the Americas* (FTAA). Canadian negotiators will face similar pressures to assume obligations that curtail public sector involvement in the economy. However, there may also be opportunities in the FTAA negotiations. Negotiators from many of the countries will be very concerned about preserving and possibly enhancing the right of governments to address social issues. Also, there may be an opportunity in the FTAA negotiations to revisit some of the more intrusive aspects of NAFTA Chapter Eleven and provide greater protection than currently exists to the right of governments to regulate in the public interest without running the risk of facing compensation claims.

Notes

1 In some provinces such as Alberta and Ontario, the legislation expressly prohibits private insurers from covering insured services under the Canada Health Act (Flood 1999, 29). However, even if there is no express prohibition, the fact that a provincial authority pays for insured services makes it unfeasible for private insurers to insure these services.

2 Canada is also party to bilateral free trade agreements with Chile, Israel and Costa Rica, as well as bilateral foreign investment protection agreements (or FIPAs) with a number of developing countries. As the economic interests in Canada of persons in these countries are negligible, the potential impact of these agreements on Canada's health care system is minimal.

3 Annex 1B of the WTO Agreement.

4 See GATS Article I:3 and Article XXIV:12 of GATT 1994.

5 NAFTA Chapter Fifteen also establishes obligations respecting state enterprises such as Crown corporations. Canada's public health care system in its present form does not depend upon the establishment and maintenance of such entities.

6 NAFTA Chapter Fifteen also establishes obligations respecting state enterprises such as Crown corporations. Canada's public health care system in its present form does not depend upon the establishment and maintenance of such entities.

7 Annex 1C of the WTO Agreement.

8 Chapter Eleven does not apply to measures covered by NAFTA Chapter Fourteen (Financial Services). While the definition of financial services in Article 1414 includes "insurance", Chapter Fourteen only applies to the cross- border provision of financial services, which is not relevant to the activities conducted by the public authorities in each province in respect of the health insurance plans. There is a corresponding exception in Article 1201(2)(a) for Chapter Twelve.

9 Pope & Talbot Inc. v. The Government of Canada (Phase 2) [unreported (April 10, 2001)].

10 Secretariat File No. USA-MEX-98-2008-01. This case involved cross-border services rather than investment but Article 1202 is similar in its structure to Articles 1102(1) and (2).

11 Article 1106(1)(c).

12 See the discussions of the potential shortcomings of the Annex II reservation in Schwartz 1997 and Appleton 2000 (pages 2 to 7).

13 Metalclad Corporation v. The United Mexican States [unreported, ICSID Case No. ARB(AF)/97/1 (August 30, 2000)].

14 Investors have challenged the agreed interpretation in several cases. The Pope & Talbot tribunal (damages phase) was highly critical of the agreed interpretation but in the end did not challenge its binding character.

15 However, Sinclair and Grieshaber assume at page 21 that GATS Article I:3(c) would be narrowly construed. This does not follow because Article I:3(c) defines scope and coverage and is not an exception.

16 CPC 8121.

17 Canada has also excluded certain services relating to health care from broader service classifications. For example, Canada has assumed commitments for Wholesale trade services described in CPC 622 but has excluded from the sector 62551 (pharmaceutical and medical goods) and 62252 (surgical and orthopaedic instruments and devices).

18 Panel Report WT/DS114/R 7 March 2000.

19 The panel struck down a considerably less significant provision of Canada's patent legislation that permitted a generic manufacturer to produce and stockpile a product during the six-month period before patent expiry.

20 The substantive provisions of which both the TRIPS Agreement and NAFTA Chapter Seventeen incorporate.

21 Annex 1A of the WTO Agreement.

22 Annex 1A of the WTO Agreement.

23 Annex 1A of the WTO Agreement.

24 Annex 4 of the WTO Agreement.

25 Annex 2 of the WTO Agreement.

26 See United States – Import Prohibition of Certain Shrimp and Shrimp Products, Panel Report WT/DS58/R 15 May 1998, Appellate Body Report WT/DS58/AB/R 12 October 1998. The Appellate Body affirmed the right of the United States to enact the environmental measures in question, which prohibited the importation of shrimp harvested by a methodology that did not protect sea turtles. The Appellate Body only took issue with the less than even-handed manner in which the measures were applied. This case has been incorrectly characterized as anti-environmental, which it clearly is not.

27 The sole exception being Article 1501 respecting competition laws.

28 In Canada – Term of Patent Protection, Panel Report WT/DS170/R 5 May 2000, Appellate Body Report WT/DS170/AB/R 18 September 2000, the United States chose to challenge Canada's law respecting term of patent protection under the DSU because the TRIPS Agreement was favourable to its case. The corresponding provision in NAFTA Article Seventeen expressly permitted the term of protection provided by Canada.

29 Or of Articles 1502(3)(a) or 1503(2), which require that governmental authority delegated to a monopoly or state enterprise be exercised consistently with certain NAFTA provisions, including Chapter Eleven.

30 A tribunal cannot award punitive damages or order a Party to change its law.

31 NAFTA Article 1120(1)(a) provides a third option, namely the ISCID Convention, but as Canada is not yet a party to that convention, this option is not, as yet, available.

32 See DSU Article 22(4) and NAFTA Article 1029(1).

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